MANAGEMENT OF BOWELS in ELDERLY PATIENTS IN HOSPITAL

**Constipation**
- Is a significant cause of delirium
- Causes physical distress (bloating, nausea, poor oral intake, vomiting)
- Causes mental distress (current older generation conditioned to have a very regular bowel habit)

Causes: change to hospital food. Poor fluid intake. Immobility, drugs (opiates, calcium tablets)

**Diarrhoea**
- Causes risk to skin integrity
- Is a source of infection risk
- Causes physical distress (rushing to toilet or being soiled in bed)
- Causes mental distress (shame when incontinent)
- Makes it difficult to obtain clean urine samples

Cause: primary bowel disease, treatment of constipation with laxative. Other diarrhea inducing drugs e.g. colchicines

*Think of red flags*: sphincter disturbance due to cord compression, blood, mucus, weight loss, whether this is part of a change in bowel habit occurring prior to admission and advice for patient if ongoing after discharge.

**LAXATIVES**

None are much good if patient has faecal impaction with hard stools in rectum

Lactulose – osmotic diuretic
- traps water in bowel predisposing to dehydration
- causes significant abdominal bloating and wind
- best avoided in frail elderly who drink little

Movicol/laxido – osmotic diuretic
- has to be taken with a full glass of water, draws less water out of gut than lactulose
- patients who don’t drink much often refuse it because of the volume

Senna tablets/liquid - stimulant laxative
- side-effect profile no worse than lactulose
- good for immobile or breathless patients (who can’t strain)

Sodium docusate /liquid - stool softener
- useful if patient very distended
- can take a few days to work

Fybogel – extra fibre
- Sets into a jelly if not drunk immediately
- Needs extra water to be drunk additionally otherwise can constipate
SUPPOSITORY AND ENEMAS (in order of potency)

1. Glycerine suppositories
2. Bisacodyl suppositories (stimulant)
3. Microlax enema
4. Phosphate enema
5. Arachis oil enema (tip the head of the bed down so patient retains it)

Glycerine suppositories (+ probably microlax enemas) are only useful if PR finds stool in rectum. If suppositories don’t work, giving them more won’t work

Never give a phosphate enema 3 days in a row or to patients with very hard large stool impacted on PR as it causes rectal necrosis

Never ask or expect nurses to administer a phosphate enema and then discharge. These can have a later flushing effect which is very bad for patients sat in the waiting room waiting for transport or actually in transit.

Phosphate and arachis oils enemas have to be retained so cannot be given to patients with poor anal tone without tipping head down (impossible if breathless etc)

Avoid managing bowels only by giving suppositories every 3 days, this may be unpleasant / undignified for some patients.

PRINCIPLES OF MANAGING CONSTIPATION – talk to your patients

- Do not aim for daily bowels open. Once every 2 - 3 days is sufficient. Avoid giving laxatives because patients want bowels to be opened daily but are not uncomfortable / asymptomatic. Explain to patient that their usual bowel habit may not occur in hospital due to change in food and mobility.
- If the constipation is due to opiates, you may need to (repeatedly) explain to patients that they are on a regular constipating drug so may need a regular laxatives, and that it is better to take opiates and laxatives than to be immobile due to pain as immobility worsens constipation
- As patients become more mobile, and eat/drink more, they will become less constipated and laxatives will need to be reduced, so monitor closely
- Look at drug chart for constipation inducing medication and to check if patient is actually taking the laxatives
- Look at the bowel chart daily
- if patient is not taking laxative, and bowels are opening, stop the laxative or change to p.r.n
- if patient is not taking laxative and is constipated, ask them why, you may need to prescribe a different one or change the time given

Note: PPIs double the risk of C difficile diarrhea, and increase recurrence by up to 5 times. Always review the need for / dose of PPIs

Do not TWOC constipated patients
Bowels not opened for 1 or 2 days

Check to see if they had admission PR
- if faecally impacted at admission, act
- if PR not done, do PR – if full rectum, act, if not, wait until 3 days,
Encourage food, fluid, mobility

Bowels not open 3 days

PR – if stool present, give glycerine suppositories AND start or increase laxatives
Start = either 1 sachet movicol od or senna 2 tablets od
Increase = increase from od to bd, or add another laxative od, then bd
DO NOT suddenly start bd lactulose and senna, or prescribe more than 2 movicols a day,
there will be sudden diarrhea in about 2 days if you do this

Bowels not open
- Microlax enema if no abdo discomfort
- Phosphate enema if uncomfortable

Bowels open
- Look at bowel chart daily
- Encourage fibre, fluid and mobility

Bowels twice a day

Type 4 or 5
- Tiny amounts – consider overflow
- Large amounts – nurses /doctors to omit laxatives for 1 day and doctors to reduce regular dose

TYPE 6 STOOL
- Stop all laxatives
- Isolate patient
- Send stool sample